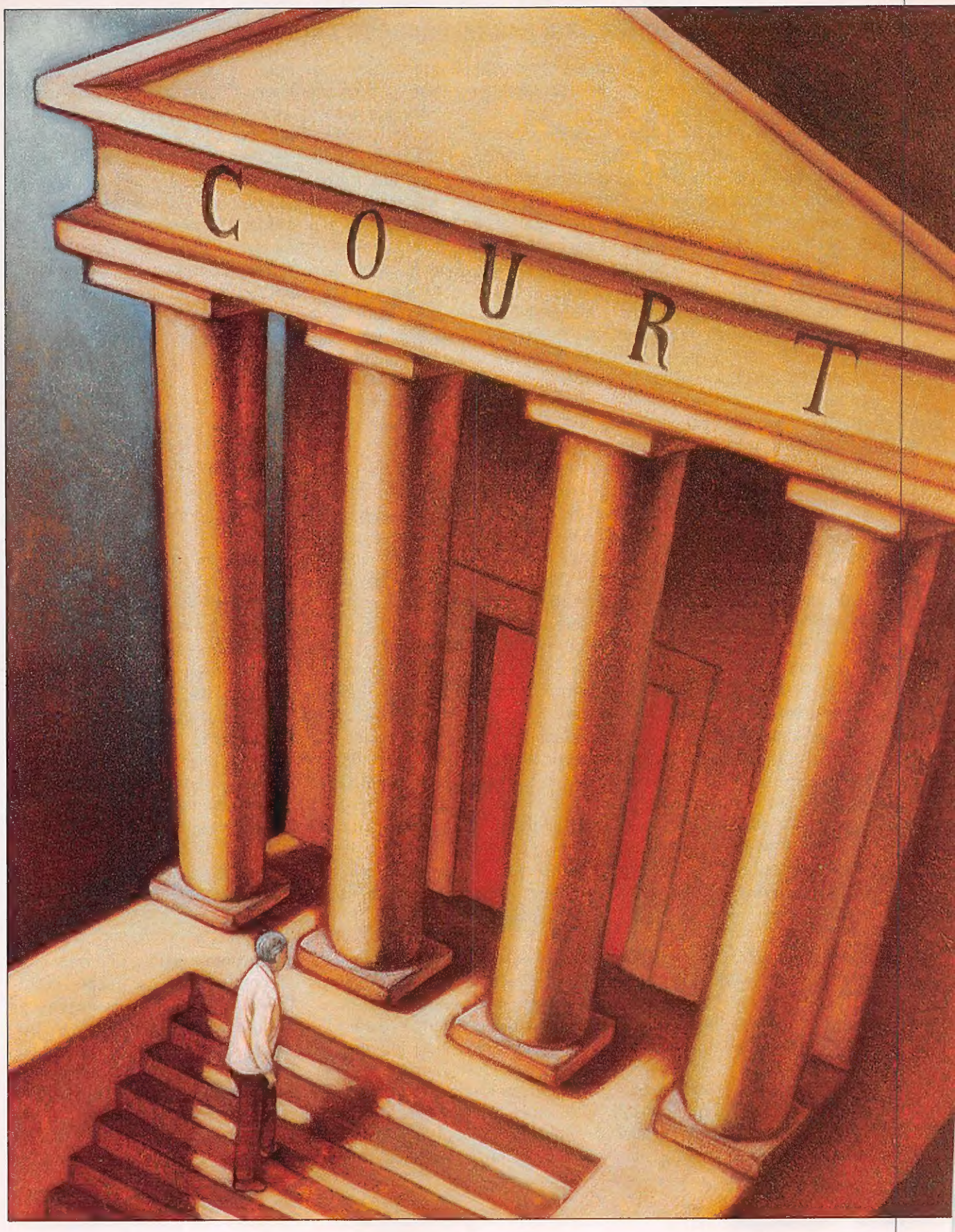
COURT

Uncle Sam wants managed care, too

Following the private sector's lead, the federal government is working to expand its managed-care menu beyond traditional HMOs.

While publicly insisting that it's not disappointed with Medicare HMOs, the Health Care Financing Administration is clearly focusing future efforts on developing Medicare PPOs. Officials reason that plateauing HMO enrollments prove that those plans aren't for everyone, and they contend that the elderly and poor should have the same managed-care options private patients do.

Three demonstration projects are already underway to test the feasibility of Medicare PPOs. In 1991, these experiments will expand into 15 states as part of HCFA's Medicare SELECT program. During a three-year trial, patients' basic Medicare coverage won't change, but beneficiaries will be offered substantially discounted Medigap supplemental policies—to cover deductibles, copayments, and uncovered services—if they agree to use network providers. "Instead of costing $800 a year, the policy might cost $600 or $700," says one HCFA official. "But to see those savings, patients would have to limit their selection of doctors to those on the PPO panel."

Where are these programs headed? Even though HCFA insists it's still just testing the PPO waters, it recently asked Congress for the authority to go ahead and set up point-of-service PPO networks for Medicare. Under these arrangements, patients who agreed to use network hospitals, physicians, labs, and durable-medical-equipment suppliers would get partial rebates on their Medicare premiums—and the government would pay discounted fees to the providers.

The plan has its critics. Some in Congress are afraid it will give the appearance of bribing patients to see cheaper, possibly inferior doctors. And organized medicine complains that it goes beyond giving beneficiaries freedom of choice, and instead strong-arms them into forsaking fee-for-service. Skeptics also question how many doctors will agree to further reductions in Medicare's already discounted fees. HCFA, however, believes the promise of treating more Medicare patients, filing less paperwork, and getting faster payments will attract enough providers to staff the new networks.

Doctors have heard such pledges before, however, particularly with regard to participation in the Medicare risk-contracting program. Yet HMOs continue to defect from the program. Eleven of Medicare's 96 HMOs dropped their risk contracts in 1991, although the number of Medicare beneficiaries in the program grew from 1.1 million to 1.2 million during the same period.

"There are a lot of problems with the program," says Marsha Gold, director of research and analysis for the Group Health Association of America, an HMO trade group. "Many plans are still looking for reassurance that future payment rates are going to be adequate."

Many HMOs worry that they'll encounter even worse payment problems if the government tries to make good on HCFA Administrator Gail R. Wilensky's promise to increase the number of Medicaid patients in managed-care plans. According to a GHAA survey published last August, some 1.1 million Medicaid beneficiaries were enrolled in 127 HMOs nationwide. But in another study, 18 prepaid health plans said they were reconsidering their participation, citing inadequate payment rates and the fact that Medicaid patients frequently lose eligibility.

Though most HMOs favor increasing incentives for plans offering prepaid care to Medicaid patients, Congress last year refused HCFA's request to financially reward states that expand managed-care offerings to the poor.

the people administering managed-care programs," says The Travelers' David Ottensmeyer. "In the past, physicians had very little accountability to anyone but their patients and peers."

But regardless of where managed care leads in coming years, it's clear that doctors will have more non-doctors looking over their shoulders to make judgments about practice patterns, quality, and charges. Given that fact, managed-care officials argue that it will be in physicians' best interests to get involved in shaping the systems in which they'll have to work.

"I think if health-care providers were to step forward and say 'Wait. We know how to manage health care, control quality, and do it at a predefined and acceptable cost,' they would find many insurance companies telling them to go ahead. Brother, I know I would," Ottensmeyer says. "But in the absence of such willingness, we'll continue to do what we do now—employ more than 1,000 doctors and nurses to review doctors." ■